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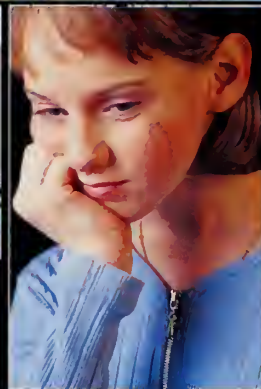
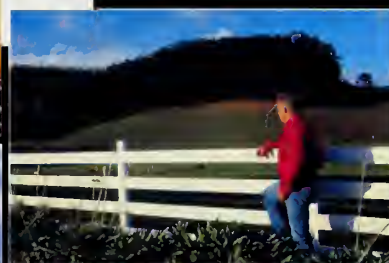


chemical dependency bureau
2002 annual report

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Addictive and Mental Disorders Division
Chemical Dependency Bureau
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 MONTANA
Department of Public Health & Human Services

CD Bureau Chief's Message

Montana's substance abuse problems are complex, widespread and expensive – we have plenty of data to demonstrate that. The good news is that we are providing real solutions. Treatment is a viable option because treatment works, and when treatment works, everyone benefits. Children and spouses are reunited with their families. Absent parents begin paying child support. People get jobs and begin paying taxes.

Follow-up information collected one year after discharge from treatment reveals tremendous success. Nearly 7 in 10 (69 percent) had not used alcohol or drugs since discharge and 57 percent reported attending A.A. or N.A. At the time of admission, 50 percent were employed either part- or full-time; one year later, this had jumped to 70 percent. And of those who had been involved with the judicial system at the time of admission, 87 percent remained arrest free one year after treatment.¹

MISSION

TO PROVIDE A CONTINUUM OF CARE IN ALL 56 COUNTIES AND TO ENSURE THE MOST EFFECTIVE AND COST-EFFICIENT UTILIZATION OF SERVICES.

The treatment system works. It's showing real, measurable results. More than that, it's providing hope for the individual, for families and for Montana.

Roland M. Mena
July 2003

Objectives from the National Treatment Plan

- Invest for Results
- "No Wrong Door"
- Commit to Quality
- Change Attitudes
- Build Partnerships



The Chemical Dependency Bureau

The Chemical Dependency Bureau administers the publicly funded prevention and treatment system in Montana. This includes a full continuum of care provided through in- and out-patient treatment services, education for DUI offenders and prevention programs. Funding comes primarily from the federal SAPT (Substance Abuse Prevention and Treatment) Block Grant, Montana's earmarked alcohol tax and Medicaid.

During FY 2002, the primary focuses of the Chemical Dependency Bureau included:

- providing a range of quality, effective services in the least restrictive, most appropriate community-based settings possible;
- increasing capacity by maximizing existing funding streams and cultivating new resources;
- bringing capacity into closer alignment with demand through managed growth;
- developing an integrated continuum of care consistent with recognizing that co-occurring disorders (e.g., chemical dependency and mental illness are both present) are the norm, not the exception;
- reducing initiation of alcohol and other drug abuse through science-based prevention programs;
- increasing effective treatment through support of research-based practices;
- expanding understanding and reducing stigma through the drug policy task force and the legislature;
- creating better transitions after treatment to help ensure success; and
- enhancing workforce and professional development.

What is addiction?

Addiction is a brain disease characterized by fundamental, long-lasting changes in the biochemical make-up of the brain. Although many of these changes can be observed through use of advanced medical techniques, such as Magnetic Resonance Imaging (MRI) or Computed Tomography Imaging (CT) scans, the disease manifests behaviorally. Some of the hallmarks of addiction include changes in mood or temperament, impaired memory processes or motor skills, and/or reduced cognitive and social functioning. These changes can occur at any stage of life, from childhood through the senior years.

¹ Montana Alcohol and Drug Information System (ADIS) data. FY 2002

Most common addictions in Montana²

- In FY 2002, 92 percent of people admitted to state-approved treatment facilities identified one of three drugs as their primary drug of abuse: alcohol, marijuana and methamphetamine;
- 62 percent of clients abused two or more substances;
- 53 percent use marijuana/hashish; and
- 27 percent of those aged 28+ in the treatment system used methamphetamine.

What is treatment?

This sounds like an easy question, but it is more complex than it appears.

- We know what treatment *offers*: hope.
- We know what treatment is *for*: to help chemically dependent individuals overcome disease.
- We know what it *does*: treatment improves lives by helping people learn to live with the addiction while changing their behavior.
- We know what *happens* during treatment: group, family and individual therapy and educational activities lead to personal change and growth.

"In this journey, we learned two important lessons. The first is that these problems can happen to anyone. The second is that treatment, when done well, works."

– Parent of a former methamphetamine addict

ADULTS WITH SUBSTANCE DEPENDENCY DIAGNOSES AND FAMILY INCOMES BELOW 200% OF THE FEDERAL POVERTY LEVEL* ARE ELIGIBLE FOR PUBLICLY FUNDED OUT-PATIENT TREATMENT SERVICES.

ADOLESCENTS WHO MEET INCOME CRITERIA AND WHO HAVE ABUSE OR DEPENDENCY DIAGNOSES ARE ELIGIBLE FOR OUT-PATIENT AND RESIDENTIAL CHEMICAL DEPENDENCY TREATMENT SERVICES.

*Eligibility for a family of 4 was \$36,200 in FY 2002.

- We know where to *find* it: in local or community-based service agencies.
- And finally, we know that it *works*, resulting in healthier lives, reduced crime and increased productivity.

But what is treatment?

Chemical dependency is an illness that results in injury to the brain and the body. Chemical dependency *treatment* is the opportunity to join a supportive environment where, though a chemical-free lifestyle, the mind, body and spirit can to begin to heal. Sobriety – the state of being alcohol and/or drug free – is the goal. The treatment environment allows people to begin to learn how to live without the chemical and to function in day-to-day life. This respite allows time to regain dignity and self respect, to recognize choice, find acceptance and hope.

Treatment services

Montana's treatment programs provide individualized care based on the American Society of Addiction Medicine (ASAM) patient placement criteria. Services are provided along a continuum of care. This includes a system through which the patient receives uninterrupted and sustained treatment in the least restrictive environment, with the appropriate level of intensity to support recovery. A list of services available in Montana follows.

- Recovery homes for mothers and children
- Education programs
- Continued care services
- Drug-free supportive living facilities
- Outcome evaluation
- Case management
- Detoxification
- Crisis intervention
- Prevention
- Individual, family and group counseling

Why is treatment important?

Addiction is a chronic and preventable disease. Left untreated, its consequences touch every facet of our society. "Abuse and addiction involving illegal drugs, alcohol and cigarettes are implicated in virtually every domestic problem our nation faces: crime; crippers and killers like cancer, heart disease, AIDS and cirrhosis; child abuse and neglect; domestic violence; teen pregnancy; chronic welfare; learning disability and conduct disordered children; poor school performance and disrupted classrooms."³

The Impact of Substance Abuse on Public Programs



² Montana Alcohol and Drug Information System (ADIS) data. FY 2002

³ *Shoveling Up: the Impact of Substance Abuse on State Budgets*. National Center on Addiction and Substance Abuse, Columbia University. 2001

The costs of substance abuse

Shoveling Up: the Impact of Substance Abuse on State Budgets is the result of three years of research by the National Center on Addiction and Substance Abuse at Columbia University. The survey was the most extensive and sophisticated ever conducted in this field. State budgets for 1998 were evaluated to determine the impact of substance abuse and addiction in 16 budget categories including health, social service, criminal justice, education, mental health, developmental disability and others. On average, of every \$100 Montana spent on substance abuse in 1998: \$96.75 was spent on the burden to public programs; \$2.82 was spent on prevention, treatment and research; and \$0.43 was spent on regulation and compliance.⁴

The Costs of Substance Abuse: Impact on Montana's State Programs*			
	Dollar Amount Budget	As Percent of 1998 State Budget	Per Capita Cost
Spending Related to Substance Abuse	\$247,503,700	**14.9%	\$281.67
Regulation/Compliance	\$ 1,100,000		\$ 1.25
Prevention, Treatment & Research	\$ 7,214,000		\$ 8.21
Totals	\$255,817,700	15.4%	\$291.13
* <i>Shoveling Up: the Impact of Substance Abuse on State Budgets</i> 2001.			
** Includes justice, education, health, child/family assistance, mental health, developmental disability, public safety and state workforce.			

State Fiscal Year 2002

• Funding Source • Population Served • Expenditures

Medicaid	
☞ Youth & Adult Treatment	\$ 906,512
Substance Abuse Prevention & Treatment (SAPT) Block Grant	
☞ Youth and Adult Treatment	\$ 3,979,075
☞ Prevention	\$ 1,021,097
☞ Synar Youth Tobacco Access	\$ 101,720
☞ Division Administration	\$ 483,159
Community Incentive Grant	
☞ Science-based Community and Youth Prevention	\$ 2,432,640

The cost benefit ratio of treatment

The success rates of good treatment programs far exceed those of treatments for diseases including cancer and other chronic, progressive illnesses.

- Tremendous public savings are generated by an investment in treatment. Recent studies reveal savings of as much as \$23 saved for every \$1 spent on treatment (Finigan, 1995). This figure takes arrests, incarceration, child welfare, social welfare and Medicaid costs into account.⁵
- The cost per client treated in FY 2002 was \$1,767.⁶
- The savings most often cited by national studies is around \$7 saved for every \$1 spent on treatment.
- Using this figure, it is possible to estimate that \$12,369 is saved for each client treated – or approximately \$69.4 million in FY 2002.

Who needs treatment?

- In 2001, as many as 53,107 adult Montanans (age 18+)⁷ were in need of treatment services.
- Among Montanans of *all* ages, 60,826 were in need of treatment.⁸
- On average in FY 2002:
 - ✓ Montana's publicly funded treatment system served 1,162 clients/month on an out-patient basis, and 223 clients/month as intensive out-patients;
 - ✓ 5,611 Montanans – or 9 percent of those needing services – received treatment; and
 - ✓ 49.3 percent were first-time admissions.
- In FY 2002, 72 percent of people admitted for treatment completed their treatment plans.⁹

2002	Treatment Component ¹⁰	Average Days
	☞ Detoxification	2.31
	☞ In-patient hospital	16.75
	☞ In-patient free standing	36.25
	☞ Halfway house	138.72
	☞ Day treatment	19.65
	☞ Intensive out-patient	55.71
	☞ Out-patient	110.13

⁴ *Shoveling Up: the Impact of Substance Abuse on State Budgets* National Center on Addiction and Substance Abuse; Columbia University. 2001. http://www.casacolumbia.org/usr_doc/47299a.pdf (Dollar amounts based on 1998 budgets).

⁵ *Cost Effectiveness and Cost Benefit Analysis Of Substance Abuse Treatment: A Literature Review* by National Evaluation Data Services 2002. Funded by the Center for Substance Abuse Treatment and the Department of Health and Human Services USA. http://neds.calib.com/products/pdfs/litrvw/cost_lit_review.pdf

⁶ Montana Alcohol and Drug Information System (ADIS) data FY 2002

⁷ Prevalence data derived from a series of assessments that began with the 1997 *Adult Household Telephone Survey*, a Substance Abuse Needs Assessment of Incoming Prisoners and a Treatment Capacity Analysis in 1997, coupled with an extensive *Need for Substance Abuse Treatment on Montana Native American Reservations, 2001*, and National Household Survey data. The results were taken from the *An Integrated Substance Abuse Treatment Needs Assessment for Montana Final Report*, September 28, 2001

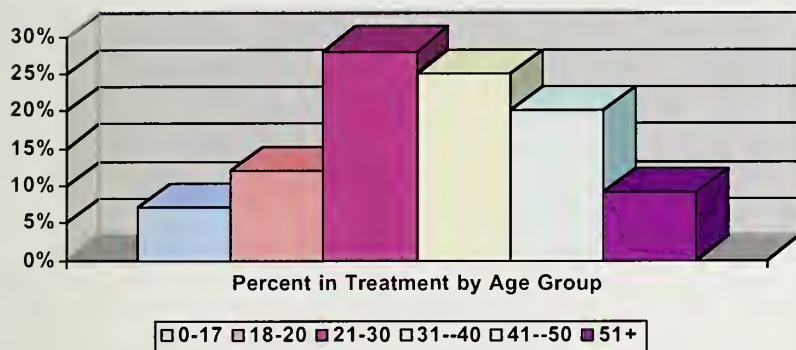
⁸ Ibid

⁹ ADIS. FY 2002

¹⁰ Ibid

Who received treatment in FY 2002?*

- 70 percent male
- 75 percent unmarried
- 37 percent involved in the criminal justice system
- 33 percent had been convicted of a DUI offence
- 40 percent employed (full- or part-time)
- 24 percent received some form of public assistance¹¹
- 11 percent women with dependent children
- 11 percent had used intravenous drugs within the past 12 months
- 6 percent homeless
- 4 percent referred by Child Protective Services



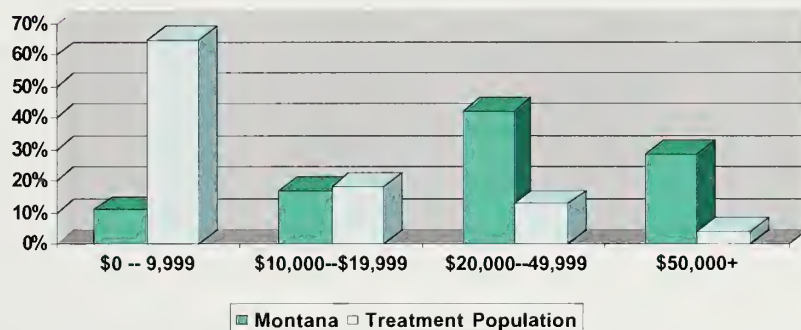
• Ages of those in treatment*

- 0 – 17: 7 percent
- 18 – 20: 12 percent
- 21 – 30: 28 percent
- 31 – 40: 25 percent
- 41 – 50: 20 percent
- 51+: 9 percent

• Annual Household Income*

The income levels of the people in state-funded treatment programs are far lower than those of Montana's population as a whole.

- ✓ **\$0 — 4,999: 48 percent**
- ✓ \$5,000 – 9,999: 17 percent
- ✓ \$10,000 – 19,999: 18 percent
- ✓ \$20,000 – 49,999: 13 percent
- ✓ \$50,000+: 4 percent



• Education*

The number of people who have a high school education or less comprises 75 percent of the treatment population, but just 44 percent of the general population of Montana.

- ✓ 0—8 years: 7 percent
- ✓ 9—12 years: 68 percent
- ✓ 13 – 16 years: 22 percent
- ✓ 17+ years: 2 percent

• Race*

- ✓ 78 percent White
- ✓ 19 percent American Indian
- ✓ 3 percent Black, Asia or Hispanic

* Demographic breakdowns were derived from MT Alcohol and Drug Information System data, FY 2002.

ACT (Assessment, Course and Referral to Treatment) Drug Court School

Montana's Drug Court Schools teach DUI offenders about the effects of alcohol and other drugs. All programs in the State of Montana follow the same course guidelines. Eighty (80) percent of those who receive DUI sentences complete court school. A year after completing ACT, 98 percent had not been rearrested for DUI.

Blood Alcohol Content at Time of DUI Arrest: FY 2002*				
.05 – .09	.1–.2	.21–.3	.31–.4	Unavailable
13%	33%	9%	1%	45%
*In FY 2002, the legal Blood Alcohol Content (BAC) in Montana was 0.1. (ADIS, FY 2002.)				

Who participated in ACT Drug Court School in FY 2002?*

- ✓ 5,589 DUI clients entered the program, down slightly from 5,707 in FY 2001.
- ✓ 77 percent of DUI clients were male;
- ✓ 78 percent were unmarried;
- ✓ 83 percent had no prior treatment for substance abuse; and
- ✓ 74 percent were employed full or part time.

¹¹ The 24% public assistance includes 2.3% TANF, 10% Medicaid, 4.2% SSI, and 7.3% food stamps.

Priority populations

Established *priority populations* take precedence over other populations when they seek treatment services. One priority population is mothers with children, born and unborn.

Mothers with children

At the time of the 2000 Census, Montana's population was almost evenly divided between the genders, with females having a slight edge at 50.2 percent. At the same time, just 30 percent of the treatment population was female. Part of the reason is likely tied to lack of transportation and appropriate childcare, but others women may avoid prenatal care and/or substance treatment for fear of losing TANF (Temporary Assistance to Needy Families) benefits or custody of their children.

Children and families are considered a "critical need population." AMDD has increased the funding directed at treating youth and their families from 5 percent in 1998 to 33 percent of treatment funds in FY 2002, changes primarily funded by Federal SAPT block grant funds.

Mothers in recovery

- 100% of the women in the mother's and children's recovery homes report personal histories of neglect, abuse and/or trauma.
 - 67% are facing child neglect or abuse charges.
 - The average age of first drug use among the women served was 12, with some reporting use as young as 5 years of age.
- Lifetime costs to care for a person with FAS exceed \$1.4 million.¹²

Critical need

- Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effect (FAE) are birth defects caused by prenatal exposure to alcohol. These syndromes are the leading causes of mental retardation and neurological dysfunction in the nation, yet are *completely preventable*.
- Montana spends about \$18.8 million annually to care for people afflicted with FAS.
- Projections indicate that in a five-year period, Montana will spend \$93.8 million on caring for people with FAS.

Mother's and children's homes

Montana has three recovery homes specifically designed to treat women and their children. The women participating must have a diagnosis of substance dependency and must either be pregnant or have dependent children. The three recovery homes are: the Carol Graham Home in Missoula; Michel's House in Billings; and the Grace Home in Great Falls.

Goal: To provide the opportunity for women and their children to participate in a comprehensive system of care that maximizes long-term physical, emotional, and social health, life skills development, self-reliance and family habilitation.

Children up to age 12 may live with their mothers in the recovery homes. Older children are included in treatment, but do not live at the recovery home. These homes provide individualized, comprehensive care and mentoring. They offer stable housing, a safe environment, opportunities to build personal and parental skills, good nutrition and a balance of work, school, appropriate play and leisure. The length of stay is up to one year, with a minimum stay of nine months.

Women pay rent in the amount of \$200 per month and are responsible for cleaning common and family areas, grocery shopping, meal preparation, laundry and caring for their children. They also attend individual and group treatment sessions, learn parenting skills and child care principles. This is often the first experience these women have with a safe, nurturing – "normal" – family environment.

SUCCESS STORIES	◆ Before Treatment	◆ After One Year
	Employed: 11%	Employed: 52%
	Average Education: 11th grade	Working toward degree or certification: 34%
	Facing legal charges other than child neglect/abuse: 33%	Arrest free: 85%
	Facing child neglect/abuse charges: 67%	Family reunified: 48%
	Substance dependent: 100%	Abstinent: 62%
		Substantial use reduction: 38%

¹² All figures in this series were taken from the Alcohol, Tobacco and Other Drug Control Policy Task Force's *Comprehensive Blueprint for the Future – a Living Document* 2002.

Women served¹³

- 89 percent unemployed
- 42 percent homeless
- 9 percent pregnant
- 97 percent diagnosed with a mental illness
- 42 percent had significant medical issues
- 82 percent had a diagnosis of methamphetamine abuse or dependency
- 70 percent had a diagnosis of alcohol abuse or dependency
- 55 percent had a diagnosis of poly-substance abuse or dependency illness (e.g., the individual uses three or more drugs)
- 45 percent IV drug users

Children served¹³

- 38 percent came from publicly funded alternative living situations, such as foster care
- 18 percent came from non-publicly funded living alternatives, such as living with a non-parent relative
- 43 percent had medical needs
- 34 percent had mental retardation, developmental delay or fetal alcohol syndrome
- 23 percent had a history of abuse and/or trauma
- 30 percent had a history of neglect
- Average age 3 - 7 years

Replicable models:

Moving toward self-reliance in the Livingston and Bozeman recovery homes

Goal: *To ensure that each client secures stable housing and employment, sufficient training and skills to promote sobriety, economic stability and self-sufficiency.*

Recovery homes provide cost-effective recovery support services in a home-like environment within the community. The homes target adults for whom recovery otherwise might be impossible. People who participate in the recovery homes have opportunities to address issues of homelessness and unemployment, are provided with substance-free housing, case management services, access to medical and psychiatric services, substance abuse treatment and skill training. The homes also offer social detoxification (e.g., non-medically managed) services when necessary. The overarching goal is self-sufficiency.

The people who live in these homes must walk a long and difficult road as they strive for a "normal" lifestyle. Success has many faces in this environment. People are staying out of jail and avoiding more expensive treatment services. They are recovering their health, working, paying restitution and child support. They are providing for their own room and board, and many are trying to reconnect with their families through support services.

Recovery homes have been designed with an eye to replication. This model emphasizes strong community collaboration and partnerships with a number of entities, including hospitals, social service agencies, mental health services and law enforcement. The dental and medical communities have provided charitable support and reduced rates. This spirit of community allows negotiations for services, which has meant reduced costs for the program and the residents.

Communities have provided solid support for the recovery homes in other ways. The faith community, civic organizations, local businesses and the AA communities have helped get the facilities ready for occupancy by donating time, labor, paint and furnishings. Volunteers continue to help by providing transportation and respite services. This support is a harbinger of **reduced stigma** and **changing attitudes**. Because the community accepts and supports the recovery homes, they are fiscally efficient, which will equate to sustainability over the long term.

The residents of the recovery homes¹³ FY 2002

- 63% male; 37% female
 - Average age: 30
 - 21% age 18 – 20
 - 25% age 21 – 30
 - 25% age 31 – 40
 - 29% age 41+
- Most were unemployed
- Primary drugs of abuse
 - Alcohol (56 percent)
 - Methamphetamine (19 percent)
 - Marijuana (19 percent)
 - Heroin (6 percent)
- 44 percent IV drug users
- 37 percent on probation
- 100 percent homeless or came from situations where recovery prognosis was poor
 - 18 percent self-referred

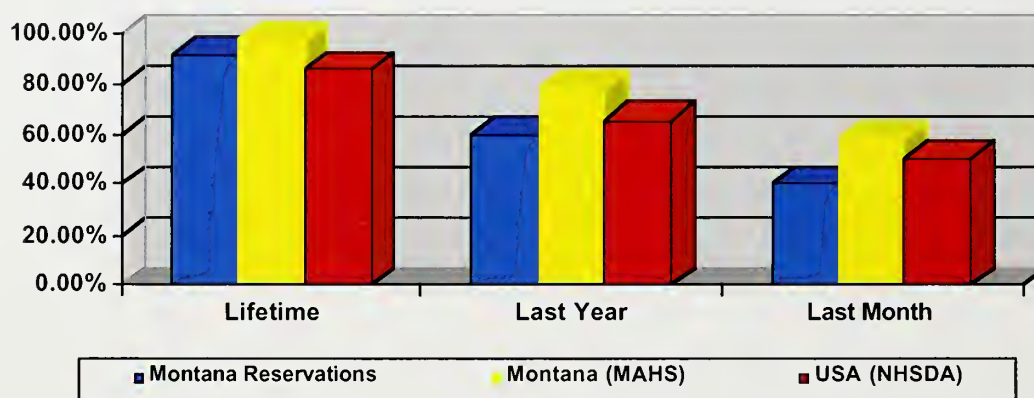
¹³ Data based on neuropsychosocial evaluations done at the individual facilities.

The Native American Study

The Need for Substance Abuse Treatment on Montana's Native American Reservations ¹⁴

AMDD conducted a study in 2001 of Native American adults (18–65 years old) living on Montana's reservations. This study was geared to assessing the use of alcohol and illegal drugs and treatment needs on Montana's reservations. The data was to be used to establish baselines, assist tribes in planning and facilitate

Comparing Alcohol Use: On and Off Montana's Reservations



access to the grant funding that would allow them to address unmet treatment needs.

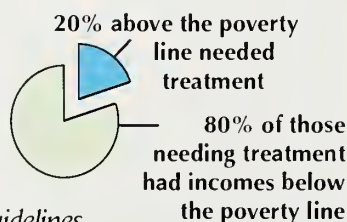
One-on-one interviews were conducted on six of Montana's seven reservations. The interviewers were chosen from among a local pool of applicants, and were tribal members; together they completed 1,861 interviews. In order to conduct this project, the governments of

these American Indian nations needed to provide their approval. The process of gaining this approval took over a year, but led to the most extensive study of its type ever conducted. The study was particularly important because the Native American population of Montana has been the target of inaccurate public perceptions relative to the use of drugs and alcohol. Interestingly, the prevalence of alcohol use among Native Americans living on Montana's reservations was lower in many cases than it was for the general population of adults in Montana and in the nation.

The need for treatment is much more prevalent among low-income households

*The results of this groundbreaking survey should not come as a big surprise to anyone in the field. Poverty on Montana's reservations – as everywhere – correlates strongly with addiction, domestic abuse and a variety of other social problems. **Poverty, not ethnicity, appears to be the strongest predictor of substance abuse** on and off the reservations.*

The problem of substance abuse on Montana's Native American reservations is not about race – it's about poverty. Eighty percent of the people who need treatment on the reservations are living below poverty levels as defined by Federal Poverty Guidelines.



The survey did reveal some disturbing trends, however. Among the Native American adults living on Montana reservations:

- The prevalence of alcohol dependence is more than three times higher (12.8 percent) than it is for other adults reported in the National Household Survey (3.7 percent).
- The prevalence of drug dependence is over four times higher (5.9 percent as compared to 1.4 percent).
- One in three young adults has an alcohol disorder; one in six has an illicit drug disorder.
- More than one in four adults (about 5,400) needs substance abuse treatment.
- About one in thirty adults (approximately 700) is seeking or receiving substance abuse treatment.
- Young men have the highest treatment need prevalence (48 percent), but are much less likely than other adults to seek treatment.
- About one in four pregnant women needs treatment for alcohol abuse or dependency.

The role of poverty cannot be overlooked when 65 percent of the people on Montana's reservations were living in households with incomes below the poverty line. The correlation is underlined by the fact that only 20 percent of those in households with incomes *above* the poverty line were in need of treatment. Even so, the number of people who need chemical dependency services on Montana's reservations provides a wake-up call.

¹⁴ The Need for Substance Abuse Treatment on Montana Native American Reservations

http://www.dphhs.state.mt.us/about_us/divisions/addictive_mental_disorders/additional/executive_summary_september_20011.pdf

The Co-Occurring Disorders Task Force

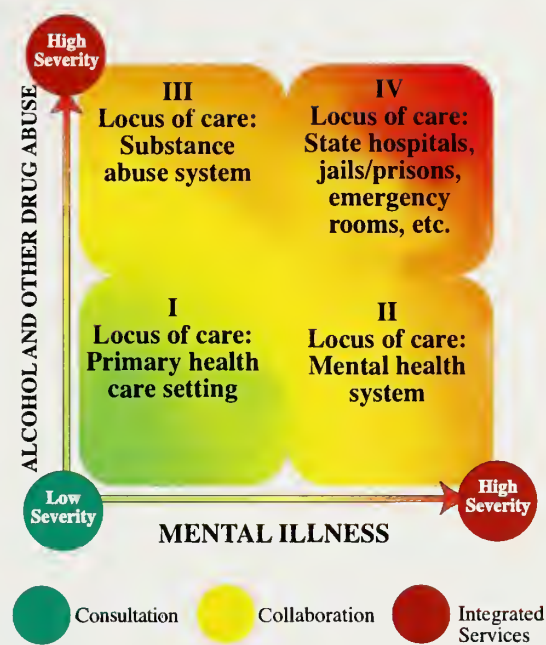
Mission: To ensure that Montana's substance abuse and mental health professionals support clients who have co-occurring disorders through a truly integrated continuum of care.

The Co-Occurring Disorders Task Force was established in November 2000. This body is comprised of mental health and substance abuse professionals, providers, consumers, advocates and social service professionals. The Chemical Dependency Bureau serves as the lead agency.

The goal for treating consumers with co-occurring illnesses is to provide a welcoming empathic, hopeful, continuous treatment relationship that provides integrated treatment and coordination of care through the course of multiple treatments."

The primary reason people do not respond to substance abuse treatment is underlying mental illness, while the reason people do not respond to mental health treatment is because of underlying substance abuse issues. At least 50 percent of both populations are struggling with the effects of substance abuse and diagnosable mental illness. Montana treatment providers have come to view co-occurring disorders as an *expectation*, not an exception.

Conceptual Framework for Co-Occurring Disorders.



Task Force accomplishments

- Developed a "cross-walk" of terminology commonly used in the mental health and chemical dependency professions;
- Assisted the establishment of a cooperative agreement between Montana State Hospital and Montana Chemical Dependency Center for the effective transfer and treatment of patients with co-occurring disorders;
- In the process of conducting a review/analysis of common screening/assessment instruments; and
- Provided education and professional skill development.

A YOUTH WHO HAS ONE PEER WHO USES DRUGS, COMES FROM A HOME WHERE THERE IS A PERMISSIVE ATTITUDE TOWARD ALCOHOL, TOBACCO OR DRUG USE, AND WHO KNOWS ONE ADULT WHO USES ALCOHOL, TOBACCO OR DRUGS HAS A 60% CHANCE OF ABUSING SUBSTANCES.

CONVERSELY, A YOUTH WITH HIGH LEVELS OF COMMUNITY AND FAMILY BONDING WILL HAVE MUCH LOWER RISK OF SUBSTANCE ABUSE.

(DRUG & ALCOHOL PREVENTION RISK & PROTECTIVE FACTOR REPORTING SYSTEM:

[HTTP://ORAWTB.HHS.STATE.MT.US:9999/PRFV_INDEX.HTM](http://ORAWTB.HHS.STATE.MT.US:9999/PRFV_INDEX.HTM))

Substance abuse prevention

Three major projects comprise the Chemical Dependency Bureau's substance abuse prevention efforts – Prevention Block Grant activities, the Prevention Needs Assessment and the Community Incentive Program. Together they form a web of efforts promoting protective factors and reducing risk factors across Montana.

Science-based research has revealed some specific environmental predictors that can signal the potential for substance abuse among children and adolescents. These include perception of use and availability, school drop-out, learning disabilities, socioeconomics and genetics. Cultural norms or familial attitudes can

encourage a path to addiction. Research – and common sense – reveals that parents are the most effective prevention resource. Parents are the first line of defence and play a key role in everything that happens to a child.

Practicing prevention

Research has revealed elements critical to predictable outcomes. This body of information is called *science-based prevention*. This is the concept that by using specific strategies in specific settings – family, school and community – it is possible to create environments in which youth are less likely to participate in risk behaviors and more likely to participate in healthy activities. This is accomplished by enhancing protective factors, reducing risk factors and changing the community norms linked to substance use.

PREVENTION IS THE PROACTIVE PROCESS OF CREATING AND SUSTAINING CONDITIONS THAT ADDRESS RISK AND PROMOTE SAFETY, PERSONAL RESPONSIBILITY AND WELL-BEING.

What are risk and protective factors?

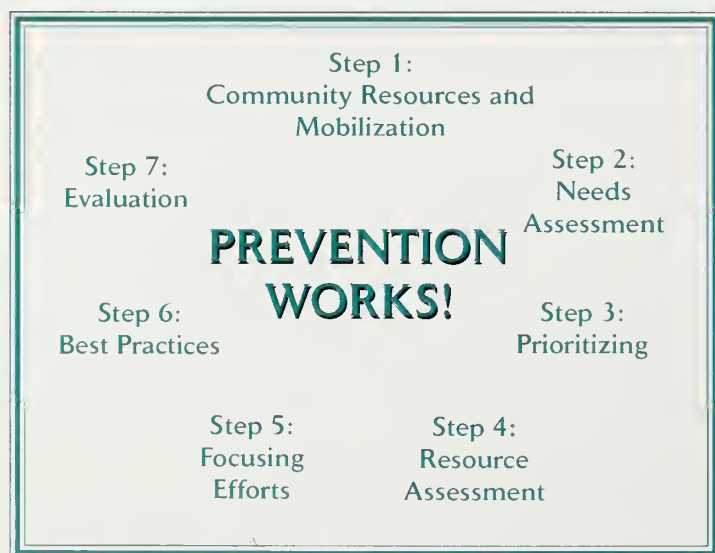
Risk factors are a combination of conditions and attitudes that increase the likelihood that a child will develop one or more problem behaviors (such as substance abuse) during adolescence. *Protective factors* are conditions that buffer young people from the negative consequences of exposure to risks by either reducing the impact of the risk or changing the child's response to that risk. Research has isolated the risk and protective factors that correlate strongly with future substance abuse among youth. Risk and protective factors are found in four life domains: community; family; school and individual/peer.

Why prevention?

Addiction begins with voluntary behavior. Alan Leshner, Director of the National Institute on Drug Abuse, calls addiction the "hijacking of the brain" because drug use physically alters the brain, creating fundamental and lasting changes in the ways it functions. What starts as a behavior of choice becomes behavior fueled by compulsion.

If the cost-benefit ratio of treatment is high, the cost-benefit ratio of prevention is nearly incalculable. Drugs permeate all of our society's most serious problems. Clearly, the costs of drug and alcohol abuse are enormous. Collateral damage includes traffic accidents caused by impaired drivers, street crime committed to support addictions and public resources expended for apprehension, sentencing, treatment and incarceration. Consider that the cost of incarcerating just *one* drug related offender is \$68.91/day at Montana State Prison and \$227.38/day at Riverside Youth Correctional Facility.¹⁵

Estimates by the Center for Substance Abuse Prevention (CSAP) indicate that for every \$1 spent on prevention, \$4 or \$5 are saved in treatment and counseling costs *alone*. During FY 2002, Montana's Chemical Dependency Bureau spent just under \$9 million on treatment and prevention. This equates to savings of \$36 - \$45 million, *without* stopping to consider the repercussions of damage to families, children, property, corrections and social service systems, medical care or lost productivity.



Building successful prevention practices

Prevention doesn't hinge on a single program. Successful prevention efforts must take a holistic approach that includes everyone in the community. There are well-defined steps for doing so.

1. Community readiness and mobilization - Assessing community readiness for implementation

Montana implemented Step #1 through the Communities That Care® model, a science-based best practice. To build prevention capacity and infrastructure, trainers were certified to assist with community building at the grassroots level. This allowed communities to learn the mobilization process at no cost. At different levels, 67 communities statewide chose to participate in the CTC Process. They were provided with technical assistance

¹⁵Offender Cost per Day by Institution: FY 2002. <http://www.cor.state.mt.us/news2002legislative/CostPerDay.pdf>

and tools to help them through the seven-step prevention process. This was the first time this had ever been done at the whole-state level. The Center for Substance Abuse Prevention (CSAP) is holding Montana up as a national example for these efforts to support communities.

2. Needs Assessment - Using a systematic process to examine current risk and protective factors

The Prevention Needs Assessment: http://oraweb.hhs.state.mt.us:9999/prev_index.htm



For prevention efforts to be effective, communities must base their decisions and actions on sound community-specific data. The Montana Prevention Needs Assessment relies on two data sources: an anonymous school survey and social indicator data. Together these tools provide a community profile and an accurate look at local risk and protective factors. Survey validity measures 97.2 percent.

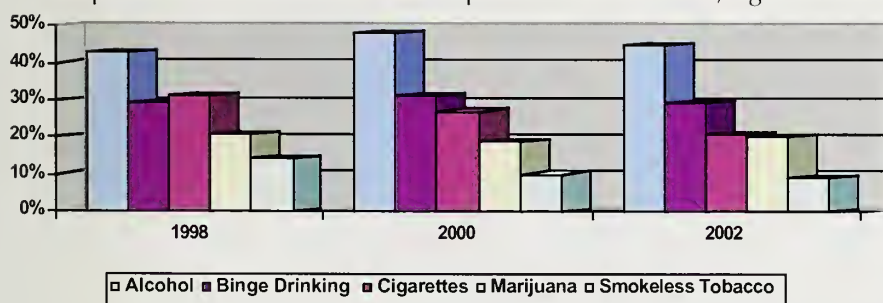
The Prevention Needs Assessment (PNA) originated with a 1997 CSAP grant. It is administered to Montana's 8th, 10th and 12th graders on a biannual basis. In addition to student survey data, 35 social indicators that correlate to adolescent substance abuse are assessed on an annual basis. These include community characteristics such as the amount of alcohol beverage tax, alcohol-related traffic fatalities, school dropout rates and drug-related juvenile arrests.

In 2002, 19,585 Montana youth provided self reports using the voluntary PNA survey. The survey is administered at a national level, making cross-state and cross-community evaluation possible.

The data is alarming. Montana ranks 2nd in the nation for illicit use of drugs, 4th in the nation for the use of alcohol and 6th in the nation for tobacco use.¹⁶ Alcohol is the substance most frequently used by Montana youth (ages 12 – 17). Cigarettes are second and marijuana is third.

Montanans have been increasingly concerned about the use of methamphetamine. This highly-addictive stimulant is readily available in many Montana communities, and can be manufactured using common household substances. Effects of this drug are devastating, and range from addiction and permanent brain damage to heart disease and stroke. Montana students are using this drug at rates lower than the national average. PNA data demonstrates that fewer students are reporting methamphetamine use: rates have dropped from a high of 3.4 percent in 1998 to 2.4 percent in 2002. Use of sedatives and hallucinogens has also dropped.

Comparison of Montana Students' Reported Substance Use, Ages 12 - 17



The good news is that many things are going right among Montana's kids

Most kids are doing fine. When asked, "Are you cool if you smoke cigarettes?" 83.8 percent said no or very little chance, or little chance. 90.3% of all ages had never received a ticket for alcohol or drugs. 82.6% of kids responded either YES! or yes to, "It's important to be honest with parents."¹⁷

¹⁶ A Coloring Book on Montana Youths' Substance Use. 2002. Prepared by the Chemical Dependency Bureau of the Addictive and Mental Disorders Division. http://oraweb.hhs.state.mt.us:9999/images/prev/download/surveys_02/colorbook2002.pdf

3. *Prioritizing* - Choosing which risk factors to address with prevention efforts

The Chemical Dependency Bureau received a State Incentive Grant to implement the Community Incentive Program (CIP) statewide. This grant was designed to build infrastructure and community capacity in support of mitigating risk and bolstering protective factors at the community level. Using PNA data, the CIP projects have been able to prioritize community risk factors. Eleven CIP communities – some among the poorest in the nation – have used these tools to build comprehensive prevention systems that meet community needs.

4. *Resource Assessment/Application* - Examining and identifying current community resources

This step involves identifying service gaps, avoiding duplication of services, building collaboration among providers, modifying existing programs to meet prevention needs and applying resources where they will have the greatest impact. The CD Bureau:

- Works closely with and provides CSAP funding for the Prevention Resource Center (PRC), and helps sponsor the PRC website at www.state.mt.us/prevention. This website provides comprehensive information about community and statewide resources.
- Funds and sponsors the *Prevention Connection Newsletter*, available online.¹⁷ The *Prevention Connection* is a 24-page publication with a distribution list of over 2,000 treatment and prevention professionals statewide. The publication is jointly published by the Addictive and Mental Disorders Division, the Interagency Coordinating Council and the Prevention Resource Center. Articles are written by Montana professionals for Montana professionals, creating a broad-based network of information sharing.

5. *Focusing Efforts* - Placing time and funding and filling the gaps

Specific CSAP (Center For Substance Abuse Prevention) strategies are used to focus efforts. They include:

a. *Information Dissemination*

- The RADAR (Regional Alcohol and Drug Awareness Resource) Network established by the Center for Substance Abuse Prevention (CSAP) responds to the need for prevention services close to home and is staffed by people who understand local assets and liabilities. Nine RADAR Associate Sites provide services to over 60 percent of Montana.

b. *Education*

- Montana issues roughly 9,000 Minor In Possession (MIP) tickets annually, to minors caught in possession of alcohol. MIP offenders are required to take the Minors in Possession course. These courses are offered under contract with the Chemical Dependency Bureau.

c. *Alternative Activities*

- These vary according to community needs and preferences. State-approved programs utilize alternative prevention activities identified by CSAP. These might include student lock-ins, camps, Red Ribbon Week activities, after-prom parties and public service activities.

d. *Problem Identification and Referral*

- Prevention specialists work with community agencies to teach the skills necessary to identify substance use and abuse. Representative activities might include: screening and referral; early identification of student problems; and health education and promotion programs for students and employees.

e. *Environmental Change*

- These activities are geared to widespread change of community policies and attitudes. Tools include conducting compliance checks and venter education under the *Reward & Reminder Program*.

PREVENTION CAN BE COMPARED TO A THREE-LEGGED STOOL. ONE LEG IS YOUTH DEVELOPMENT AND EDUCATION, ONE IS THE DISCUSSION OF HARM, THE THIRD IS ESTABLISHMENT AND ENFORCEMENT OF COMMUNITY NORMS.



¹⁷ Prevention Connection Newsletter: <http://www.state.mt.us/prc/resources/prevconn/prevconn.htm>

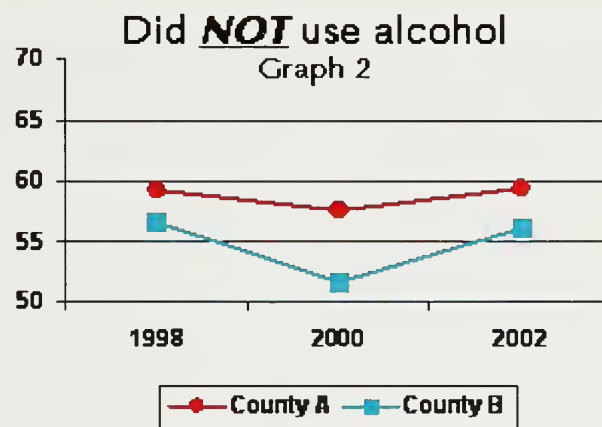
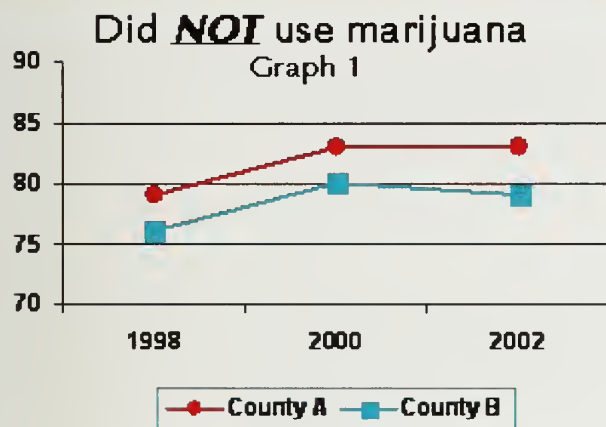
6. Best practices - Research and evaluation-supported strategies

State-approved agencies provide programs based on Center for Substance Abuse Prevention (CSAP) best prevention practices. These activities are typically targeted at adolescents and their parents. They are classroom based and may include such programs as *Smart Moves*, *Media Literacy*, *In My House*, *Strengthening Families* and *FAST*. All eleven CIP communities were required to implement best practices.

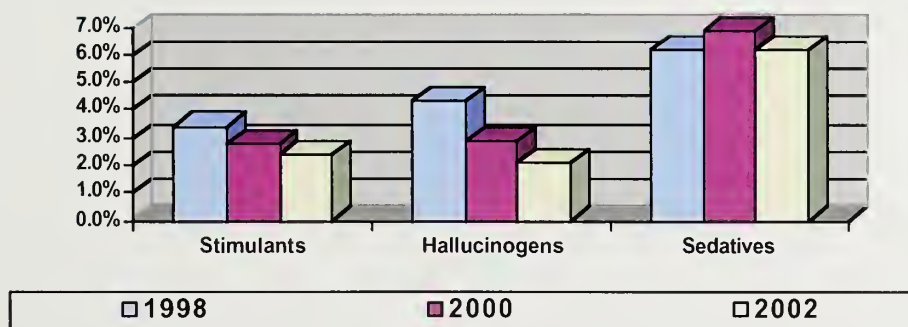
7. Evaluation - Systematic efforts to collect and use community information for multiple purposes

The Prevention Needs Assessment (PNA) has allowed Montana to make deliberate changes that result in measurable outcomes. Early PNA data serves as a baseline against which the success of the actions and activities described above can be measured. Data was collected in 1998, 2000 and 2002. As demonstrated by graphs 1 and 2 on this page, students in "County A" – where strong prevention efforts have been in place for the past five years – reported measurably healthier behaviors during the 30 days prior to the survey than did their counterparts in County B, which had been largely unserved during the same period.

In a comparison of Prevention Needs Assessment (PNA) data over time, it is possible to demonstrate that measurably fewer kids engage in risk behaviors such as marijuana and alcohol use in communities that apply prevention measures.



Among 8th, 10th, & 12th graders, use trends of many substances are down.



Successful prevention

Developmentally, adolescents are at an age to challenge authority and take risks. *The right message and prevention activities must be geared to the appropriate developmental stage, and delivered in the right media so that it can be heard and retained.* The best efforts are cost-effective and promote understanding of the dangers and harm of given behaviors. Montana's concentrated prevention efforts have made strides toward meeting the needs of a huge and diverse state, its communities and families.

Eleven communities statewide have implemented the Communities That Care® process. Their efforts have been supported by CIP funds and focused over the long term. Their successes have been hard-won and noteworthy. Not only have these communities provided good models for others in Montana, but they have received nationwide attention. There are many, many successes to be proud as a result of these projects, but one representative example has been chosen from each community.

✓ **Billings**

After working for two years to institute prevention curriculum in the schools, Billings has brought a systematic best-practice prevention curriculum to all grades, K-12. Regardless of the school attended, all Billings students receive the same prevention message.

✓ **Boys and Girls Club of the Northern Cheyenne Nation**

The Northern Cheyenne Boys and Girls Club provides a safe haven for kids from preschool through college age. The club provides job training through a print shop, life skills training, and mentoring in cultural tradition. The Boys and Girls Club concept is a best practice, but the Northern Cheyenne have molded it to fit their culture. Their adaptation has been recognized as a best practice prevention program specific to Native American cultures.

✓ **Flathead Reservation and Lake County**

Through the CTC process – and by using CIP funding as a foundation – tribal and county governments have come together in support of strengthening *all* children. The Flathead Reservation & Lake County Coalition for Kids, Inc. has joined forces under a 501(c)(3) umbrella that formalizes their partnership, and which will allow them to sustain their comprehensive prevention plan.



Smart Moves - Boys & Girls Club of the Flathead Reservation

✓ **Gallatin Valley Communities That Care**

This project was part of a national cross-site process to evaluate the CTC process. Because of their meticulous implementation efforts to mobilize the community, the Gallatin Valley CTC Program has been recognized nationally as a model program.

✓ **Great Falls**

Great Falls has worked with all of its agencies and coalition members to focus on evaluation, and is using the logic model to guide all community prevention efforts and evaluation. Because of this – and additional coalition building – they have been able to focus their efforts on a variety of prevention issues.

✓ **Missoula**

Through the CIP Process, Missoula now has the Flagship Mentoring Program in all of their schools. These programs are not only best practices, but they promise to be sustainable over the long term.

✓ **Park County**

This CIP Project has succeeded in getting into every school in Park County with a Big Brothers, Big Sisters Program, which pairs younger children with high school mentors.

✓ **Prairie County**

In this ranching community, the gap identified was among young children who were not old enough to work on the family farms. The community rallied to create a summer program based on best practices. It offers safe places, lifelong learning skills and good nutrition. This program also feeds into the best practice programs implemented during school time.

✓ Ravalli County

Ravalli has implemented 20 best-practice programs in support of children, families and the community. These programs evolved into the Family Resource Center, which will be sustainable long term.

✓ Sheridan County

A computer club, chess club and after-school program are the hallmarks of this community's prevention efforts. The gap identified was the lack of activities available to young children, primarily in grades 4-6. These programs address those identified needs.

✓ West Yellowstone

Helping Hands, a 501(c)(3), was established under the CIP program; West Yellowstone and has grown into a prevention Mecca. Helping Hands implemented numerous programs with focuses ranging from prevention through intervention. Together, these activities address the unique needs rising from a high concentration of itinerant workers and tourists.



CIP - Children of Families and Students Together (F.A.S.T.)

chemical dependency bureau

2002 annual report resources

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Drug and Alcohol Prevention Risk and Protective Factor Reporting System:

http://oraweb.hhs.state.mt.us:9999/prev_index.htm

State Approved Chemical Dependency Treatment Programs:

http://www.dphhs.state.mt.us/services/office_locations/chemical_dependency/state_approved.htm

Prevention Resource Center

www.state.mt.us/prevention
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406-444-5986
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Prevention Resource Center VISTA Project:

<http://state.mt.us/prevention/VISTA/vistainfo/americorps.htm>

Prevention Connection Newsletter:

<http://www.state.mt.us/prc/resources/prevconn/prevconn.htm>

Weekly Hot News listserv

http://state.mt.us/prevention/resources/Hot_News/hot_news.asp



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http://www.dphhs.state.mt.us/about_us/divisions/addictive_mental_disorders/addictive_mental_disorders.htm

Resources (continued)**Governor's Alcohol, Tobacco and Other Drug Policy Task Force**

<http://www.discoveringmontana.com/gov2/css/drugcontrol/default.asp>

Comprehensive Blueprint for the Future: A Living Document

http://www.discoveringmontana.com/gov2/content/drugcontrol/FINAL_ATOD_Task_Force_Report.pdf

Need for Substance Abuse Treatment on Montana's Native American Reservations. 2001.

http://www.dphhs.state.mt.us/about_us/divisions/addictive_mental_disorders/additional/executive_summary_september_2001.pdf

Substance Abuse and Mental Health Services Administration

<http://www.samhsa.gov>

Center for Substance Abuse Prevention (CSAP)

<http://www.samhsa.gov/centers/csap/csap.html>

Center for Substance Abuse Treatment (CSAT)

http://www.samhsa.gov/centers/csat2002/csat_frame.html

Shoveling Up: the Impact of Substance Abuse on State Budgets

National Center on Addiction and Substance Abuse; Columbia University. 2001

http://www.casacolumbia.org/usr_doc/47299a.pdf

A Coloring Book on Montana Youths' Substance Use, 2002.

Addictive and Mental Disorders Division's Chemical Dependency Bureau.

Montana Department of Public Health and Human Services.

http://oraweb.hhs.state.mt.us:9999/images/prev/download/surveys_02/colorbook2002.pdf



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